



Fertility Specialists  
Medical Group, Inc.

Fertility Specialists Medical Group, Inc.  
8010 Frost Street, Plaza Level, San Diego, CA 92123  
Phone (858)505-5500 Fax (858) 505-5555

**MALE PATIENT INFORMATION FORM**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
LAST FIRST MI MO DAY YR

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

CELL PHONE # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_ BIRTH PLACE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ FULL / PART TIME

EMPLOYER ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

RELIGIOUS PREF \_\_\_\_\_ DO YOU HAVE ANY ALLERGIES? \_\_\_\_\_

ADVANCE DIRECTIVE FOR HEALTHCARE/LIVING WILL  NO  YES (IF YES, ENCLOSE COPY OF DOCUMENT)

**PARTNER INFORMATION  NONE**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
LAST FIRST MI MO DAY YR

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

**OTHER CONTACT**

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HM # \_\_\_\_\_ WK # \_\_\_\_\_  
STREET CITY STATE ZIP

**INSURANCE INFORMATION**

FULL NAME OF PRIMARY INSURANCE \_\_\_\_\_  
INSURANCE PHONE # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_  
MEMBER # \_\_\_\_\_ EFF DATE \_\_\_\_\_  
NAME of POLICY HOLDER \_\_\_\_\_

FULL NAME OF SECONDARY INSURANCE \_\_\_\_\_  
INSURANCE PHONE # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_  
MEMBER # \_\_\_\_\_ EFF DATE \_\_\_\_\_  
NAME of POLICY HOLDER \_\_\_\_\_

All of my insurance coverage is listed above (primary, secondary and tertiary, insurance if applicable). I disclosed all pertinent information and I am giving permission to bill my insurance. \_\_\_\_\_ initials.

## MALE PATIENT INFORMATION FORM (CONTINUED)

**AUTHORIZATION:**

I understand that I am financially responsible for all charges, including initial consultation whether or not covered by my insurance company. Payment is due at time service is rendered unless insurance is being billed.

**ASSIGNMENT:**

I permit payment directly to Fertility Specialists Medical Group, Inc. for any benefits due for services rendered.

**MEDICAL RECORDS:**

1. Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original.
2. Authorization is hereby granted for release of pertinent information to a hospital or to the referring physician for appropriate continuum of care/treatment as required. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collection your insurance claim or for negotiating a settlement on a disputed claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**E-MAIL:**

This email will not be used for transmittal of health information or given to any 3<sup>rd</sup> party. This email will only be used for notification of upcoming events and E-Newsletters.

E-MAIL: \_\_\_\_\_

**AUTHORIZED PHONE NUMBERS TO LEAVE MESSAGES:**

When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call. May we leave messages, such as lab results, appointments, or other medical information on an answering device, or with another person who answers the phone, at that number? Yes  No

Phone number(s): \_\_\_\_\_, \_\_\_\_\_

**INTENDED PARENTS:**

Due to increasing technologies and social changes, it needs to be clear who are the intended parents of any intervention you undertake under our care. Please write down who are the intended parents after responding to the following question.

- There is one (1) intended parent
- There are two (2) intended parents
- Not Applicable, as I am not seeking care for my own attempts at reproduction or parenting.

Signature \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

**DISCLOSURE TO ONE ANOTHER:**

By signing below I certify that all information related to me and my partner's care can be shared between us by the staff at Fertility Specialists Medical Group, Inc.

Patient Signature \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_